STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155493	A. BUILDING **03** B. WING _____	**06/24/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS AT THE MONASTERY	**710 SUNRISE DRIVE** **FERDINAND, IN 47532**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code and Environmental Preoccupancy Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a) for the relocation of two (2) beds from room 704 to 706 and 708. Room 704 will now have zero (0) beds. Rooms 706 and 708 will now each have two (2) beds. Survey Date: 06/24/25 Facility Number: 000534 Provider Number: 155493 AIM Number: 100267220 At this Life Safety Code and Preoccupancy survey, Scenic Hills at the Monastery was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2, Environmental and Physical Standards of Indiana's Health Facilities Rules for Comprehensive care facilities in regard to the Life Safety Code and Environmental Preoccupancy Survey. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 88 certified beds and had a census of 61 at the time of this survey. Additionally, the 600 Unit of the	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155493	A. BUILDING **03** B. WING _____	**06/24/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS AT THE MONASTERY	**710 SUNRISE DRIVE** **FERDINAND, IN 47532**

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K 000	Continued From page 1 facility which included 23 Assisted Living beds was surveyed due to the lack of a two hour fire barrier separation from the 700 Unit Memory Care which was for Comprehensive Care beds. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 06/26/25	K 000		